CAI
YL15
-M22

3 1761 11630986 5

MEDICARE IN CANADA

Government
Publications

Current Issue Review

79-24E

CAI
YL15
-M22

Medicare in Canada

Garth McNaughton
Political and Social Affairs Division
Research Branch

18 September 1979
Reviewed 15 May 1987

Library of Parliament
Bibliothèque du Parlement

Research Branch

The Research Branch of the Library of Parliament works exclusively for Parliament, conducting research and providing information for Committees and Members of the Senate and the House of Commons. This service is extended without partisan bias in such forms as Reports, Background Papers and Issue Reviews. Research Officers in the Branch are also available for personal consultations in their respective fields of expertise.

© Minister of Supply and Services Canada 1987

Cat. No. YM32-1/79-24-1987E

ISBN 0-660-12585-4

N.B. Any substantive changes in this Review which have been made since the preceding issue are indicated in **bold print.**

CE DOCUMENT EST AUSSI
PUBLIÉ EN FRANÇAIS

CA1
YL 15
-1979
C24

CANADA

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

MEDICARE IN CANADA

ISSUE DEFINITION

Although the Constitution Act, 1867 gives the provinces responsibility for health services, the federal government became involved in this field by providing conditional grants to upgrade and maintain the levels of health care in all parts of Canada. Under the Medical Care Act, federal funds were made available for provincial health insurance programs if certain criteria were met: comprehensive coverage, universality, portability, non-profit administration. Concern has been voiced about rising costs, accessibility of medical services and adherence to the principles of the Medical Care Act. Universal access to services has appeared to be threatened by the number of physicians who have opted out of provincial plans or who have adopted the practice of extra-billing and by the application in some provinces of hospital user fees. On the other hand, it has been asserted that co-payment mechanisms have been made necessary by rising costs and underfunding of the system. The debate on the erosion of medicare has involved issues concerning jurisdiction, the extent of federal funding and the practices of opting out, extra-billing and charging hospital deterrent fees. This debate has been heightened by the withholding of federal grants from those provinces which continue to permit extra-billing and user fees after the passing of the Canada Health Act in 1984.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

BACKGROUND AND ANALYSIS

A. A Federal Medicare Scheme

Canada's national health insurance system -- medicare -- was achieved in two stages. In 1957 the Hospital Insurance and Diagnostic Services Act provided for the cost of provincially operated hospital insurance plans to be shared by the federal government. The Medical Care Act in 1966 extended federal cost-sharing to provincial plans insuring doctors' services.

One of the key issues in the formulation of a national system was the question of jurisdiction. In Canada, health matters in general fall within provincial jurisdiction. Furthermore, it had been decided at the highest court level that the power to levy a direct premium on residents in a matter pertaining to health and welfare came under the jurisdiction of the provinces. Therefore, barring constitutional amendment, any program of national health insurance could be implemented only through programs administered by the provinces.

The federal government, however, was able to become involved through the avenue of funding. In 1957 the mechanism of providing conditional grants to the provinces was used for hospital insurance. After the establishment of this program, pressure mounted for the introduction of a comparable medical insurance plan. The Royal Commission on Health Services (the Hall Commission) in 1964 recommended such a universal medical insurance program. The Commission's recommendations were largely followed in the medicare plan subsequently established. The program allowed for federal funding provided that the provinces met certain conditions. These conditions - the 'five principles' of Canada's health insurance plan - are comprehensiveness, accessibility, universality, portability and public administration. Thus, provincial plans must have the following characteristics:

(1) Comprehensive coverage for all medically required services rendered by a physician or surgeon. There can be no dollar limit or exclusion except on the grounds that the services are not medically required.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

(2) Uninhibited access to necessary services requires that the benefit coverage be administered in such a way that there will be no impediment or preclusion through financial charges or otherwise to an insured person receiving necessary medical care.

(3) Universal availability to all eligible residents of a participating province on uniform terms and conditions and covering, in addition, at least 95% of the total eligible population.

(4) Portability of benefits when the beneficiary is temporarily absent from his province and when he is moving from one participating province to another.

(5) Administration on a non-profit basis by a public authority which is accountable to the provincial government for its financial transactions.

The Medical Care Act passed in December 1966 specifically outlined these criteria. Any province with a medical care plan which met the basic points was eligible for a federal contribution, which was based on 50% of the national coverage per capita cost of the insured services of the national program times the average for the year of the number of insured persons in the provinces. On the inaugural date of 1 July 1968 only two provinces, Saskatchewan and British Columbia, qualified. The others followed and by April 1972 all the provinces and territories had joined.

Medicare has benefited Canadians in general. It has been especially helpful to the poor since there is a relationship between low income and poor health. But Medicare has also enabled the medical profession to avoid "bad debts" and to receive their fees on a regular and reliable basis.

However, health care funding is failing to meet rising costs. The growing reliance on hospital care, diagnostic tests and sophisticated technology has increased health care expenditures. At the same time, the aging of the Canadian population requires the expansion of facilities. **The impact of AIDS on health care costs is just beginning to be contemplated.** Alternatives to the present health care model have been suggested, including more extensive use of the nursing profession to

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

provide more cost-effective health care, homecare services and community health centres. Some health care reformers are proposing the adoption of U.S.-style Health Maintenance Organizations (HMOs) that provide care for a flat annual fee per patient, as a means to curb escalating costs in Canada. The Toronto General Hospital has approached Ontario Health Minister Murray Elston about setting up Canada's first HMO.

B. Federal Contributions to Health Care

The original financing arrangements for both hospital and medical insurance presented problems for both the federal and provincial governments. Concern about the open-ended nature of health cost sharing agreements was voiced federally, while the Provinces complained about the lack of flexibility in allocating their resources. At the June 1976 First Ministers' Conference, the Prime Minister tabled a block-funding proposal regarding major shared-cost programs in health and post-secondary education. It eliminated the 50-50 cost sharing formula, calculated federal payments independently of provincial expenditures and required provinces to spend the funds in the fields in question but not necessarily to make matching expenditures.

This proposal led to the passage in 1977 of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act. Commencing 1 April 1977 federal contributions to the established programs of hospital insurance, medical care and post-secondary education would no longer be directly related to provincial costs, but would take the form of a transfer of tax points to the provinces and a three-part cash payment. This legislation also amended the Medical Care Act by adding subsection 6(4) requiring a province as a condition of payment to supply information to show that its plan satisfies the criteria described in the original Act. In addition to withholding payments, the federal government could also give three years' notice of its intention to terminate the payments and a new arrangement would be negotiated.

The Parliamentary Task Force on Federal-Provincial Fiscal Arrangements supported the retention of the block-funding approach. It recommended a two-stage process whereby the present Fiscal Arrangements Act

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

would be renewed. Intergovernmental consultations on program conditions and measurement criteria would follow. A consolidation of the existing legislation including clearly defined conditions would conclude this process. The Task Force agreed that federal payments should be "conditional on compliance with program criteria, but conditional in a flexible manner - that is, with a graduated holdback of the federal transfer related to the extent of achievement of program conditions."

In his November 1981 Budget, the federal Finance Minister announced his plan to cut $5.7 billion from federal transfers to the provinces in the next five years for social programs, including medicare and post-secondary education.

In the autumn of 1985, the Nielsen Task Force (Ministerial Task Force on Program Review) reported that it disagreed with the federal government's announced intention of reducing the amount of transfer payments to the provinces by an additional $6 billion by 1990. It also criticized Ottawa for the unilateral division of Established Program Financing into separate health and post-secondary education components in 1984, saying that the federal initiative was inconsistent with the concept of "block funding." The Task Force expressed concern that federal efforts to reduce transfer payments "could substantially reduce its role in Canada's health care system." The percentage of federal government contributions to provincial health programs is currently at approximately 40%. There has been a gradual diminution in the proportion of total health care expenditures financed by the federal government since 1979-80.

C. Additional Charges (Extra-Billing)

Because physicians are private practitioners, not civil servants, it has been necessary in introducing universal medical insurance to strike a balance between government control and private enterprise. The first province to introduce a medicare scheme, Saskatchewan, discovered this when its new legislation was greeted by a 23-day physicians' strike in 1962. Finally, concessions were made regarding the relationship between doctors and the government, and part of the settlement involved the use of

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

private insurance companies to process claims, thus allowing doctors to practise without direct contact with the government insurance commission.

Remuneration of doctors is predominantly on a "fee-for-service" basis. Prior to medicare, provincial medical associations established fee schedules which were frequently used as a basis for payment by government and private insurance arrangements. Because payment from such plans was assured, doctors were generally willing to accept a prorated payment since the medical association schedule included an allowance for bad debts, repeated billings, bookkeeping costs and collection charges. A similar approach was taken after the Medical Care Act was passed; payment schedules of the plans are negotiated with the medical profession and represent a level of payment that most doctors will accept.

Mr. Justice Emmett Hall in his Health Services Review '79 found that extra-billing denies access to many of the poorer elements of society and violates the essential principle of accessibility to all. The Canadian Medical Association, on the other hand, supports the right to charge such fees to "offset the underfunding" of health care. A majority of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements concurred with the recommendations of Mr. Justice Hall to prohibit extra-billing and with the proposal for binding arbitration when negotiations between physicians and the province fail.

Rising office expenses and the desire to maintain a high income led many physicians to charge their patients more than the fees set up by the provincial health commissions. Although medical profession officials have argued that extra-billing is applied only to those who can afford it, several studies have indicated that this is not so. A study for the Canadian Centre for Policy Alternatives found that up to 93% of some medical specialists in Alberta extra-bill, and that they sometimes do so for all patients (including those on welfare).(1) In December 1984, the National Anti-Poverty Organization (NAPO) released a report providing case histories of low-income people who have been adversely affected by extra-billing, user fees and health care premiums. The report suggests that poor

(1) Richard Plain, "Charging the Sick: Observations on the Economic Aspects of Medical Social Policy Reforms," CCPA, November 1982.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

people often avoid necessary medical treatment if they know or think that their doctor extra-bills. The NAPO report mentioned a recent Gallup Poll which found that 79% of Canadians are opposed to extra-billing, and used this with their own study to call on governments to eliminate direct health care charges.

D. Deterrent Fees or User Fees

Hospital user charges have been permitted in Canada provided that they do not affect "reasonable access" to services. Advocates of such charges feel that they are necessary to ensure patient responsibility in seeking medical aid and lessen the number of visits for minor or unnecessary treatment. Those who oppose deterrent fees call it a regressive tax since one is taxing the ill rather than spreading the cost among all taxpayers.

The Ontario Economic Council found that deterrent fees neither deter people from using health services, nor reduce the costs of such services, and that the introduction of deterrent fees only provides more money to the provincial treasury, doctors and insurance companies. Deterrence would occur only if the cost were excessively high, and then, many individuals would turn to private insurance plans. In 1979 the Ontario Council of Health issued a report which indicated that user charges for medical services result in some reduction in utilization and that the groups most affected are the socially disadvantaged, the poor and the elderly. There was no evidence that user charges would result in a substantial decline in the unnecessary use of hospital and medical services.

The Parliamentary Task Force on Federal-Provincial Fiscal Arrangements stated that "user charges that are high enough to serve as deterrent fees deter the wrong people (the old and the poor, for the most part), while user charges that are low enough to be acceptable on distributional grounds are too low to be worth collecting - administrative costs more than match any revenue gains." Between 1958 and 1978, hospital user charges were in effect in five provinces. By 1980 Newfoundland, New Brunswick, Alberta and British Columbia allowed user fees while in Ontario and Quebec some charges were made for chronic care.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

Provincial health ministers continue to look for ways to reduce hospital costs and health expenditures. For example, in September 1984, Alberta Hospitals Minister Dave Russell announced that hospitals will be permitted to keep whatever surplus is left over from provincial operating grants at the end of the year as an incentive to efficient operation.

E. Federal Initiatives

In Health Services Review '79, Mr. Justice Emmett Hall recommended prohibition of extra-billing and the use of binding arbitration in cases where physicians and a province could not agree on fees. In its report Fiscal Federalism in Canada, the Task Force on Fiscal Arrangements recommended retention of the block-funding arrangement, stricter monitoring of adherence to the principles of medicare, the graduated holdback of funds where standards are not maintained and abolition of premiums and user fees.

On 25 July 1983 the Minister released a document Preserving Universal Medicare: A Government of Canada Position Paper which stated that "medicare is being eroded by the spread of direct charges in the form of user charges and extra-billing." It refuted charges of under-funding and denied that the cost of health care is excessive or that Canada's health care spending is "out of control."

On 12 December 1983, the Canada Health Act (Bill C-3) was introduced in the House of Commons. It declared an objective of the national health care policy to be the facilitation of access to services without undue financial barriers (s. 3). The purpose of the Act as set out in section 4 is to advance policy objectives "by establishing criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services .... provided under provincial law."

For a province to qualify for a full cash contribution, no payments are permitted under the provincial insurance plan for insured services that have been subject to extra-billing and user charges other than those prescribed by the regulations. Where a province fails to comply with these provisions, the amounts charged for a fiscal year through extra-billing or user charges shall be deducted from the cash contribution

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

to the province for a fiscal year. Where extra-billing or user charges are eliminated during the three fiscal years following the coming into force of the Act, the amounts deducted are to be returned to the province (s. 20).

In April 1984, Bill C-3 became law. By July 1984, the federal government began penalizing provinces which continued extra-billing and hospital user fees. For every $1 the provinces received in extra-billing, $1 of federal health grants were withheld. Those provinces ending extra-billing within three years could recover the lost grants in 1987.

After the Conservatives came into power in September 1984, the new Health Minister Jake Epp reaffirmed his commitment to abolishing extra-billing and user fees. Yet he adopted a more conciliatory approach than his predecessor and vowed not to interfere with provincial jurisdictions or tell provincial ministers how to run their medicare plans. What the federal government will do should provinces allow physicians to evade extra-billing laws by charging for uninsured services (as may be the case in Ontario) is an open question.

Health and Welfare Canada commissioned studies in 1984 to investigate the possibility of privatizing parts of the health care system. The Sherman Report concluded in 1985 that the system as it exists now works well and costs would likely rise if significant segments of the health care system were privatized. The other report, by health economist Greg Stoddart, pointed out that the debate over the merits and demerits of privatization is not enlightening or productive. The real problem, he pointed out, is the separation of clinical decision-making authority over utilization of the health care system from the financial responsibility of paying for the levels of service that result from those clinical decisions.

In November 1986, Health Minister Epp presented a discussion document entitled Achieving Health for All: A Framework for Health Promotion that proposes options for encouraging Canadians to take charge of their own well-being. The document was published by the Minister to initiate a nation-wide consultation exercise on developing new approaches to health promotion.

F. Some Provincial Initiatives

Several provincial health ministers have questioned the degree of federal intervention in health care. The provincial health

LIBRARY OF PARLIAMENT
BIBLIOTHEQUE DU PARLEMENT

ministers met in September 1983 and agreed that it was not necessary to ban extra-billing and user fees to preserve medicare principles and that federal contributions to the medicare system were not keeping pace with rising health costs and had fallen below the intended 50%.

Quebec, Newfoundland, Nova Scotia and Prince Edward Island were the only four provinces to avoid penalties because they banned extra-billing and user fees before the Canada Health Act. By March 1987, New Brunswick and British Columbia, the last two provinces paying financial penalties for not complying fully with the Canada Health Act, announced that they would fall in line with the law. Their statement came three days before the federal deadline requiring provinces to comply with the Act or forego transfer payments withheld by Ottawa. In Quebec, extra-billing was always unprofitable for doctors because patients could not be reimbursed by the government if a physician charged more than the health plan benefit level.

In Ontario, the Liberal government ended extra-billing with the Health Care Accessibility Act, passed 12 June 1986. Under this Act doctors can be fined up to $10,000 for charging more than OHIP fees. The Ontario Medical Association held a 25-day strike to protest this legislation in June and July of 1986.

In spite of the legislation, however, some Ontario physicians have found two ways to charge more. One is an "administrative fee" to cover the costs of extra medical services that are not paid by OHIP (e.g., medical supplies such as drugs and disposable diagnostic instruments, telephone advice, renewals of prescriptions without assessments, filling out doctors' certificates, consultations by the physician with allied health professionals and interviews with others on behalf of patients). The second method, used primarily by psychiatrists and obstetricians, is a surcharge for being "available" or on standby when the patient suddenly requires help.

There is widespread confusion about the legitimacy of the supplementary charges physicians are making. The confusion stems from the fact that there is no comprehensive guide to which services are insured by OHIP and which are not. Many people argue that administrative and other

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

supplementary fees are simply extra-billing in disguise -- that doctors have exercised their ingenuity to get around a law many of them hold in disdain. The province has been more reserved in its judgment, however, partially in an attempt to maintain the uneasy peace it has tried to develop with physicians since the summer strike.

After urging from the Ontario government and the College of Physicians and Surgeons, the OMA published guidelines for what it considers acceptable charges to patients but it has been conspicuously silent about the practice of some doctors of charging fees for being available. Provincial Health Minister Murray Elston has stated that he believes many of the supplies for which the OMA says doctors are entitled to charge are already covered under OHIP.

Between the passing of the law banning extra-billing and 13 May 1987, OHIP received 318 complaints from people who believed they had been extra-billed. Many of the complaints involved specialists from groups that frequently extra-billed before the ban was made law. Under the law, the provincial health insurance plan will repay patients for overcharges on insured services. OHIP can take this amount out of the future payments bound for the doctor. **As of 13 May, 210 patients had been reimbursed.** Patients will also be reimbursed, although none have yet been, when doctors' administrative fees are made a condition for getting care.

In early February 1987, the Ontario Health Minister warned that he might begin prosecuting doctors who consistently bill patients above OHIP rates. While the Ministry has recovered extra-billings from 10 physicians (as of May 11), there have as yet been no prosecutions. However, unless the provincial government passes new regulations clarifying the intent of the extra-billing ban, the ambiguity about insured and uninsured services will continue, and OHIP will not be able to judge in all instances whether a patient has been illegally charged or not.

The province is in a dilemma: if it declares all extra charges to be illegal, the result could be a repetition of confrontation; should it incorporate into the OHIP schedule the services doctors claim are uninsured, it could drain the treasury and doctors might find another way

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

around the law anyway; however, should it continue to allow doctors to make additional charges, the "ban" on extra-billing will have changed nothing.

A dispute has emerged between the Quebec government and doctors in Ottawa that is perhaps indicative of the struggle by Ontario physicians to sustain their incomes. In November 1986, orthopedic doctors in Ottawa told Hull-area hospitals that, except in life-threatening situations, they would not accept transferred patients unless the Quebec hospitals paid Ontario fees for services rendered in Ottawa. Quebec's medical plan pays doctors on average 35% less for services than OHIP. The Ottawa branch of the Ontario Medical Association recommended that all local doctors require Quebec patients to pay Ontario rates, even though patients are reimbursed only at Quebec rates. This situation may be in contravention of the portability provisions of the Canada Health Act.

A coroner's jury in Ontario has recommended that midwifery be legalized and procedures for training and accrediting midwives be initiated. The Ontario government has announced that this recommendation will be accepted. A major study of the organization and objectives of Ontario's health care system had been suspended during the discussions of the Health Care Accessibility Act, but commenced again in the fall of 1986. It is headed by former University of Toronto president John Evans.

Legislation to stop doctors from opting out of medicare and charging more than the provincial health insurance fee schedule was passed in Manitoba and was effective as of 1 August 1985. In exchange for their loss of rights, Health Minister Desjardins offered the doctors an arbitration procedure to settle medicare fee disputes. However, by early 1987, Canada's first experiment in binding arbitration was in trouble. The provincial government threatened to terminate the agreement unless a provision could be negotiated limiting the volume of medical services for which the province is billed.

Saskatchewan was losing $160,000 a month due to extra-billing but legislated against the practice in August 1985. Saskatchewan doctors held a series of rotating one-day strikes in June 1986 when they felt the government had broken its part of the deal to ban extra-billing, which was supposed to let physicians control how the annual increase in the

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

fee schedule was distributed among different specialist groups. The government gave in within days.

In September 1986, the Alberta government won doctors' approval to ban extra-billing. With approximately 25% of physicians charging more than negotiated fees in 1985, the province had among the highest rates of extra-billing. Under the new agreement, a doctor who extra-bills must opt out of the health care insurance scheme and neither the doctor nor the patient is eligible for reimbursement from the insurance scheme. (This is similar to the regime that prevails in Quebec.) In exchange for an end to extra-billing, the Alberta government agreed to provide $12 million more in increased fees and benefits for doctors. Hospitals will be required to drop the admission fees introduced in 1983, but will be reimbursed by the provincial government for their loss. The agreement also dropped cosmetic surgery as an insurable service under the provincial plan. In November 1986 the federal government announced that it would return $29 million to the province under the terms of the Canada Health Act.

The Alberta government has also announced options for curbing health care costs. Most controversial are suggestions that patients pay doctors' bills directly and be reimbursed from the insurance plan, and that there be a rationing of the number of insured benefits any patient can claim. The province is also launching a new scheme to catch dishonest doctors by asking patients to confirm they have received the treatment for which their physicians have billed.

In British Columbia, the Social Credit government passed legislation in May 1985 to restrict billing numbers to new doctors in certain areas of specialization and regions of the province (Medical Services Amendment Act). In January 1987, the B.C. Supreme Court upheld the legislation. Mr. Justice Kenneth Lysyk ruled that the law does not violate the Charter of Rights and Freedoms by erecting a barrier to inter-provincial mobility. In the wake of the court ruling, the Manitoba government indicated that it, also, was seriously contemplating restrictions on the number of doctors who can work in any given part of the province.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

Battles between the medical profession and provincial governments are not only about the right to extra-bill or to have a Medicare billing number, they are about professional versus political control over the health care system and the question of accountability. There is a growing contradiction between the desire of doctors to have the final say on how many tests and operations will be performed or how long a patient should remain in hospital and the government imperative to contain costs. Moreover, the cost of public health insurance is increasingly forcing trade-offs between equality and freedom, and between access and quality, that will only become more difficult as time passes.

There is concern in some quarters that bans on extra-billing may result in reductions in the number of insurable services under medicare, as governments attempt to control costs. In Ontario, the removal of wisdom teeth is no longer covered by OHIP. In Alberta, cosmetic surgery has been removed from the provincial insurance plan. In November 1986, the Alberta Hospitals Minister acknowledged that he was considering de-insuring the annual medical check-up. In January 1987, the Manitoba Health Minister said that his government was also considering demanding that patients pay the cost of health services that are judged, by an independent ethics committee, to be unnecessary. In addition, the province might allow private insurance companies to enter the health field to provide coverage for medical services deleted from the public insurance plan.

G. Responses of Professional Associations

The Canadian medical profession has argued that the Canada Health Act fails to address the main problem of medicare which it identifies as underfunding. As evidence of underfunding, it has cited long waiting lists for hospitalization, overcrowded emergency departments, staff cutbacks and a lack of money for new equipment. In the view of the Canadian Medical Association and its provincial divisions, the real problem of underfinancing has made direct charges necessary.

Doctors are acutely concerned that government preoccupation with controlling costs will lead inevitably to arbitrary decisions by the state about what services, treatments and technologies will be available

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

and a diminution of professional control over the health care system. Many physicians believe that an adequate health system cannot be financed entirely by taxation but must be supplemented by private funding. At the same time, there appears, to some extent, to be an expectation that existing practices should not be changed and that more money should be found to finance current patterns of use.

Spokesmen for the CMA have stated that the overall success of medicare has involved the cooperation of doctors, the overwhelming majority of whom have participated without compulsion. They argue that the Canada Health Act now compels participation, lessens doctors' civil rights compared to those of other citizens and may encourage some doctors to leave the country in search of a more favourable working environment.

In its brief to the Commons Standing Committee on Health, Welfare and Social Affairs in February 1984, the Canadian Nurses' Association, while generally agreeing with the objective of the Act, stated that the long-term viability of medicare requires a reorientation of health policies and a restructuring of the use of health care professionals.

In 1984, the report of the task force commissioned by the CMA and headed by Joan Watson concluded that underfunding is not the major problem of the health care system. Major reforms, especially in services for the elderly, were suggested in the report.

The Canadian Medical Association has taken steps toward a court challenge of the Canada Health Act as unconstitutional. They claim it denies doctors the right to deal with their patients as they wish. In May 1985, the B.C. Medical Association lost its case to retain "balance billing" when the Supreme Court of Canada declared it illegal.

PARLIAMENTARY ACTION

A. Hospital Insurance and Diagnostic Services Act, 1957

This legislation involved conditional grants from the federal government to the provinces which administered individual hospital insurance programs.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

B. Medical Care Act, 1966

The Medical Care Act passed by Parliament in 1966, established the basis for a national medical care insurance plan with prescribed criteria.

C. Amendments to Medical Care Act, 1976

As a result of funding problems the Medical Care Act was amended in 1976 to impose ceilings on the amount of escalation of medical care costs that would be accepted for sharing purposes.

D. Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977

Changes to the funding arrangement for health insurance were enacted by legislation in March 1977. The shared-cost arrangement was replaced by a tax transfer and cash payments tied to the GNP.

E. Parliamentary Task Force Report, 1981

The report, released in August 1981, recommended renewal of the provisions of the 1977 Fiscal Arrangements Act for three years and consolidation of the various pieces of federal health care legislation.

F. Amendments to the EPF Act, 1977

On 5 April 1982 the House of Commons passed Bill C-97.

G. The Canada Health Act, 1984

The Canada Health Act (Bill C-3) was introduced in the House of Commons on 12 December 1983, amended, and passed third reading on 9 April 1984. On 17 April it was passed by the Senate and received Royal Assent.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

CHRONOLOGY

1867 - The Constitution Act, 1867 gave to the provinces the responsibility for the provision of health care services.

1946 - The Saskatchewan Hospitalization Act was passed.

1957 - The Hospital Insurance and Diagnostic Services Act was passed by the federal Parliament.

1958 - Hospital insurance programs began in five provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Newfoundland).

1961 - The Saskatchewan Medical Care Insurance Act was passed. After a three week strike by physicians in 1962, some amendments were made.

1964 - The Royal Commission on Health Services (the Hall Commission) recommended a medical insurance program similar to the hospital program.

1966 - The Medical Care Act was passed by Parliament.

July 1976 - Amendments to the Medical Care Act imposed limitations on the amount of federal contributions to medical care costs.

March 1977 - Established Programs Financing Act was passed. As a condition of payment, a province must show that its plan satisfies the criteria of medicare (comprehensive coverage, uninhibited access, universality, portability and non-profit administration).

September 1980 - Release of report from Health Services Review '79.

August 1981 - Report of Task Force "Fiscal Federalism in Canada" rejected user fees; majority against extra-billing; majority agreed with binding arbitration; recommended withholding federal funds if standards not maintained.

April 1982 - Bill C-97 amending the Established Programs Financing Act, 1977.

July 1983 - Government of Canada Position Paper entitled Preserving Universal Medicare stated that direct charges are eroding medicare and proposed new legislation.

September 1983 - Provincial Health Ministers met in Halifax and stated the need for more Medicare funds.

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

April 1984 - The Canada Health Act was passed by Parliament and received Royal Assent.

July 1984 - Federal health grants were withheld from those provinces continuing extra-billing and hospital user fees. Ontario forfeited the highest amount of money.

May 1985 - Federal and provincial health ministers met in Winnipeg to discuss the future of medicare.

January 1986 - Ontario Medical Association protested against the Health Care Accessibility Act (Bill 94).

June 1986 - Bill 94 to ban extra-billing in Ontario was passed.

June-July 1986 - Ontario doctors held a 25-day strike to protest Bill 94.

June 1986 - Saskatchewan doctors held a series of rotating one-day strikes to protest an alleged breach of the deal to ban extra-billing.

June 1986 - Health Minister Epp outlined options for reform of health promotion and disease prevention programs.

September 1986 - Alberta government and doctors reached an agreement banning extra-billing.

November 1986 - Health Minister Epp presented a discussion paper entitled Achieving Health For All: A Framework for Health Promotion.

January 1987 - B.C. Supreme Court upheld legislation which allows the province to control both the supply and the distribution of doctors.

SELECTED REFERENCES

(1) Badgley, Robin F., and R. David Smith, User Charges for Health Services, Ontario Council of Health, Toronto, 1979. (Library of Parliament RA185/05/A351/1979/U84)

(2) Bird, Richard and Roderick Fraser, Commentaries on the Hall Report, Ontario Economic Council, Toronto 1981. (Library of Parliament J103/P1/1979/H4/A122)

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

(3) Canada, Government of Canada, Preserving Universal Medicare, Ottawa, 1983.

(4) Canada, Health Services Review '79, Canada's National Provincial Health Program for the 1980s, Ottawa, 1980. (Library of Parliament J103/P1/ 1979/H4/A12)

(5) Canada, Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, Fiscal Federalism in Canada, Ottawa, 1981. (Library of Parliament J103/H7/1980-1 F4A12)

(6) Canadian Centre for Policy Alternatives, Medicare: the Decisive Year, Proceedings of the CCPA Conference on Medicare, Ottawa, 1984.

(7) Evans, Robert G., "Health Care in Canada: Patterns of Funding and Regulation," Journal of Health Politics, Policy and Law, Vol. 8, No. 1, Spring 1983, p. 1-43.

(8) National Anti-Poverty Organization, No Care Medicare, Ottawa, December 1984.

(9) National Council of Welfare, Medicare: The public good and the private practice, Ottawa, May 1982. (Library of Parliament RA184/M43)

(10) Sherman, Louis, Management by Private Contract: a Study for the Minister of Health and Welfare, Winnipeg: Associated Health Planners, 1985.

(11) Stoddart, Greg L., Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options, a study prepared for the Minister of National Health and Welfare, Ottawa, 1985,

ACCO®

ACCOPRESS™

YELLOW	25070	JAUNE
*BLACK	25071	NOIR*
*BLUE	25072	BLEU*
RL. BLUE	25073	RL. BLEU
*GREY	25074	GRIS*
GREEN	25075	VERT
RUST	25078	ROUILLE
EX RED	25079	ROUGE

ACCO CANADA INC.
WILLOWDALE, ONTARIO

* INDICATES 75% RECYCLED 25% POST-CONSUMER FIBRE

*SIGNIFIE 75 % FIBRES RECYCLÉES, 25 % DÉCHETS DE CONSOMMATION

BALANCE OF PRODUCTS 25% RECYCLED

AUTRES PRODUITS: 25 % FIBRES RECYCLÉES


0 50505 25072 1